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HEALTH CARE CO-OPS: A REVIEW OF THE FINANCIAL AND OVERSIGHT CONTROLS

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HEALTH CARE CO-OPS: A REVIEW OF THE FINANCIAL AND OVERSIGHT CONTROLS

THURSDAY, JANUARY 21, 2016

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:44 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Crapo, Cornyn, Thune, Burr, Portman, Toomey, Heller, Wyden, Cardin, Brown, Bennet, and Casey.

Also present: Republican Staff: Chris Campbell, Staff Director; Chris Armstrong, Deputy Chief Oversight Counsel; Kimberly Brandt, Chief Healthcare Investigative Counsel; Katie Meyer Simeon, Health Policy Advisor; and Jill Wright, Detailee. Democratic Staff: Michael Evans, Chief Counsel; Elizabeth Jurinka, Chief Health Advisor; Juan Machado, Professional Staff Member; and Joshua Sheinkman, Staff Director.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order. I would like to welcome everyone to today's hearing on financial and oversight controls for health care CO-OPs.

Six years ago, the so-called Affordable Care Act was forced through Congress and signed by President Obama. The law was passed on a series of strictly partisan votes over the opposition of the majority of the American people, and, at that time, supporters of the law claimed it would both expand health coverage and bring down costs.

Not surprisingly, as the health law has been implemented, reality has had a different story to tell. Under the Affordable Care Act, millions of Americans learned the hard way that, despite many promises to the contrary, they could not keep their previous health care plans, even if they liked them.

Under the Affordable Care Act, health insurers, unable to sustain the losses resulting from the law's draconian mandates and regulations, are dropping out of exchanges across the country. Under the Affordable Care Act, insurance premiums are rising, at astronomical rates in some parts of the country, and options for patients and consumers are decreasing seemingly by the day.

Under the Affordable Care Act, the so-called Consumer Operated and Oriented Plans are failing left and right. These Consumer Operated and Oriented Plans, or CO-OPs, are the subject of today's

hearing. The CO-OP program was designed to encourage the development of a nonprofit health insurance sector, which, according to its proponents, was supposed to improve coverage, increase competition, and provide more affordable health care options. But, as with many other parts of the health law, reality has told a different story with regard to the CO-OP program.

Taxpayers have been forced to foot the bill for the CO-OP experiment to the tune of $2.4 billion, with a "b," in Federal loans for 23 CO-OPs around the country, and, to date, more than half of the CO-OPs have failed, while the vast majority of the others are in poor financial shape. As a result, hundreds of thousands of Americans have lost or will lose their health insurance, and taxpayers are still on the hook.

In some ways, the CO-OPs were doomed to fail from the outset. For example, they have been limited to less profitable markets, had no historical claims data, and had no brand recognition or trust. Some were established and run with political aims in mind rather than solvency or efficiency. Several had premium prices that were far below that of their competitors and, not surprisingly, they incurred costs that far outpaced revenue.

Standard and Poors aptly described establishing a CO-OP as, quote, "learning to ride a bike without training wheels."

There are a number of questions we could ask about the CO-OP program, and we certainly will today. Why was it designed so poorly? Why are there not more safeguards in place to protect taxpayer investments? Of course, many of these questions should be directed at those who actually wrote and passed the health law in the first place, none of whom will be testifying in this hearing.

However, today we will hear from Andy Slavitt, the Acting Administrator of the Centers for Medicare and Medicaid Services, which oversees the CO-OP program.

From a congressional oversight perspective, the main question we have today is, how has CMS dealt with these problems? As it turns out, we know at least part of the answer. CMS has actually encouraged the CO-OPs to cook their books with some creative accounting. Last year, the agency issued guidance allowing CO-OPs to apply surplus notes to program startup loans, which essentially allowed the CO-OPs to record loans as assets in their financial filings.

Quite honestly, I think I am being generous when I call that kind of accounting "creative." Yet, it is, as far as we know, now the standard of practice among Obamacare CO-OPs.

Today, I want to hear more about these types of creative ideas coming from CMS, because I believe the taxpayers deserve some explanation, particularly those taxpayers who lost their coverage when the CO-OPs they enrolled in were not financially viable enough to provide them with the coverage they were promised.

Mr. Slavitt, you currently oversee an agency that is responsible for paying out well over $1.1 trillion through Medicare and Medicaid each year, a number that, by the way, will only go up in the coming years. And while the current program is a relatively small drop in the bucket, it is still a significant investment on the part of American taxpayers.

So I look forward to hearing your explanation of what is going on with this program and your ideas about what can be done to improve the situation.

So with that, I will turn to Senator Wyden.

[The prepared statement of Chairman Hatch appears in the appendix.]

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Thank you very much, Mr. Chairman.

When Congress wrote the Affordable Care Act, it gave Americans shopping for health insurance the option of getting coverage from new private nonprofits called Consumer Operated and Oriented Plans, or CO-OPs. More than 1 million people turned to CO-OPs for insurance in 2015, including many very vulnerable Americans who needed access to top-notch care. That is certainly evidence that there is real demand for CO-OPs, and lawmakers should be focused on making sure CO-OPs provide the services that consumers need and deserve.

That is not how the events have played out. Even though the Supreme Court has upheld the Affordable Care Act multiple times, the political battles have continued, and CO-OPs are one of the big targets.

Now, right out of the gate, CO-OP funding was handicapped by a cut of two-thirds. Their financial flexibility was the next thing to go. Congress denied the ability to move resources that would help new CO-OPs weathering growing pains to continue serving consumers. So from the get-go, these private insurance plans have been facing extraordinarily stiff headwinds.

In my State, 15,000 people got insurance coverage from Health Republic, one of our State's two CO-OPs. It fell victim to this totally avoidable financial crunch and announced last October that it was closing, due, in large part, to the inability of the Congress to set politics aside and work together on a bipartisan basis to improve the law.

Fortunately, there is still a marketplace where those 15,000 Oregonians can shop for high-quality insurance, and there are several more CO-OPs up and running across the country, including the second one in my home State, called Oregon's Health CO-OP.

Now, some may want to paint the CO-OPs as kind of token failed government, but the facts do not bear that out. Let us start by remembering what CO-OPs are and what they are not. CO-OPs are not government-run and they are not, for example, the public option that was at the center of the Affordable Care Act debate 6 years ago.

CO-OPs are private, market-driven plans that now cover hundreds of thousands of Americans. In my view, these CO-OPs are startups that had early investors. They drew up business plans. They attracted customers and opened their doors. Then their investments were yanked away. So it is no wonder that some of them have run into trouble.

My view is—and I will certainly be repeating this, colleagues, throughout this session—we ought to be looking for bipartisan approaches to strengthen the Affordable Care Act and CO-OPs, while

stoking private competition and private choices in insurance marketplaces nationwide so that consumers can benefit.

The fact is, the battle lines over the Affordable Care Act are familiar now to just about everybody. The House and Senate have taken dozens and dozens of votes on proposals that undermine or repeal the ACA. Now, some may not want to hear this, but the Affordable Care Act is not going to be repealed.

Americans do not want to root out protections for our citizens who have preexisting conditions and go back to the days when health care in America was for the healthy and wealthy. What we ought to do is get on with the bipartisan challenges that our country needs to attack to improve health care.

I see our colleague, Senator Grassley, is here, former chairman of the committee. I want to thank him, because he worked with me side-by-side for 18 months on what I think is going to be a landmark investigation into how blockbuster drugs are priced. Hepatitis C drugs are what Senator Grassley and I were looking at: Sovaldi and Harvoni.

We said from the outset, every bit of our inquiry was going to be bipartisan, and I want to thank Senator Grassley for his efforts in that regard, because that is how I think we ought to be working.

The reality is, we are going to have great health care cures in America, colleagues, great cures, and what Senator Grassley and I looked at is a question about whether Americans are going to be able to afford these great cures.

Those challenges can only be addressed in a bipartisan way.

Now, fortunately, we are beginning to make some additional progress in other areas, and I am very pleased that Chairman Hatch, with the help of Senator Isakson and Senator Warner—and I have joined in on these efforts—has begun a serious effort to address what I think is also a big part of the future of Medicare, and that is tackling chronic disease.

Where most of the money now goes is into diabetes and cancer and heart disease and strokes. We have begun an important inquiry, with Chairman Hatch, Senator Isakson, and Senator Warner, to bring a chronic care bill before the Finance Committee.

That is, colleagues, my view of how we ought to be pursuing health care. We have a chance to start pulling on the same end of the rope when it comes to these big issues, and I look forward to working with my colleagues on these questions.

Finally, I want to thank Acting CMS Administrator Andy Slavitt for joining us today. It is my view that he is an excellent nominee for the job of CMS Administrator. In the last 6 months since he was officially nominated, he has proven himself on the job, and I particularly appreciate that he has been accessible to all the members on both sides of the aisle here on the Finance Committee. So I am very hopeful that Mr. Slavitt's nomination can be moved as quickly as possible.

Thank you, Mr. Chairman.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. Thank you, Senator Wyden.

Now, I would like to take a few minutes to introduce today's witness—Senator Wyden has partly done that—Acting Administrator Andy Slavitt.

Mr. Slavitt is currently serving as the Acting Administrator for the Centers for Medicare and Medicaid Services. In that role, he is responsible for overseeing the coverage of 140 million Americans under Medicaid and Medicare, the Health Insurance Marketplaces, and the Children's Health Insurance Program.

Prior to joining CMS in July 2014, Mr. Slavitt spent over 2 decades working in the private sector, spending most of that time working on health care and technology. Most recently, Mr. Slavitt served as group executive vice president for Optum. He has also served as the CEO of OptumInsight, as well as the founder and CEO of Health Allies, prior to which he was a strategy consultant with McKinsey and Company and an investment banker with Goldman Sachs.

Mr. Slavitt lives in Minnesota with his wife and two teenaged boys. He graduated from the Wharton School and the College of Arts and Sciences at the University of Pennsylvania and received his master's of business administration from the Harvard Business School.

Mr. Slavitt, we are honored to have you here. We would like you to please proceed with your opening statement.

STATEMENT OF ANDY SLAVITT, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. SLAVITT. Thank you. Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for the invitation to participate in this hearing on the CO-OP health insurance companies.

I know you are aware of the challenges CO-OPs have faced as they started up operations, 11 having closed their doors prior to the third open enrollment. So I will focus my comments today on providing the committee with a review of CMS's oversight responsibilities and lessons we have learned from moving forward as we work to protect consumers and oversee taxpayer dollars.

As you know, CO-OPs were created to stimulate new competition in an industry that has a history of being very difficult for small companies to enter, with some entering markets that had not seen a new competitor for decades. CMS's principal role is to grant and oversee loans and then maximize the likelihood that Federal funds are returned. We are in close contact with State regulators, as they, of course, have full authority over insurance companies in their State and oversee the rules CO-OPs operate under.

Now, by the time I became Acting Administrator in February 2015, all the CO-OPs had been selected, all the loan funding had been obligated, and the major strategic and operating decisions were in the hands of the CO-OP boards.

I came to CMS with a principal focus on execution and implementation across all of our programs, and my principal focus with the CO-OP program has been to ensure that we have the best pos-

sible oversight practices and personnel as we move to this new stage of the program.

One of the very first things I did was to hire an independent firm to do a review of all these companies. Now, these are very small businesses—typically with 30 to 50 employees, trying to compete in a market filled with large established firms—that needed very active oversight.

We established tailored oversight protocols, a formal risk committee, and an enhanced monitoring process. In 2015, we conducted 27 financial and operational reviews, 16 in-person visits, and had 43 formal communications, not to mention hundreds of phone calls, and we have kept the States up to speed on every important interaction to help them perform their regulatory actions.

Now, as we move forward, there are several lessons from the first 2 years of the program which are important for CO-OPs and for those of us charged with the taxpayers' and consumers' interests.

Let me start with CMS. We need to make it easier for CO-OPs to attract outside capital or a merger partner if the board chooses. We need to level the playing field and lengthen the runway for these small businesses. That is why shortly we will be releasing guidance and exploring further steps to ease that path for CO-OPs and investors.

Second, States should continue to take prudent and conservative actions to protect consumers. Sometimes this does mean putting in place enrollment freezes, and sometimes it means making the difficult decision not to certify a plan for the coming open enrollment. Because of the States' decisive actions, each of the consumers in the CO-OPs that closed at the end of last year maintained coverage until the end of the year, and, so far this open enrollment, nearly three-quarters of CO-OP marketplace consumers have continued their coverage in new plans.

As a steward of taxpayer funds, we also appreciate the States' collaboration and decisiveness, as it increases the likelihood that we will get higher amounts of funds returned.

Finally, the single biggest factor in the future success of the CO-OPs will come from the actions of the companies themselves. As small companies, they need to rapidly mature the fundamentals of their operations and, in particular, their financial systems, which are vital to the ability of any insurance company to predict, manage, and control costs. They need to tighten their operating discipline and CO-OP processes and hold their vendors accountable in this and other areas in the year ahead.

Through all the challenges they face, CO-OPs have every opportunity to become successful, long-term market participants. When I meet with them and hear their stories, I am reminded that many of the men and women working in these not-for-profits are serving poorer and sicker communities that had not been traditionally served in the health-care system.

Even in States where CO-OPs proved unsuccessful, in the first year, the overall uninsured rate in CO-OP States decreased by 20 percent, and it has continued to improve.

Ultimately, our goal at CMS is to make sure that the programs we are charged with are working as they should for American fami-

lies. As we enter the third year of exchange operations, millions of Americans have found coverage for the first time, and hundreds of private-sector companies are competing for their business.

Challenges like the ones we are discussing today are part of every program, and we must always be ready to work through them transparently, with accountability, with urgency, and in the best interest of the taxpayers and consumers we serve.

Thank you, Mr. Chairman, for allowing me these few minutes, and I am now pleased to take your questions.

[The prepared statement of Mr. Slavitt appears in the appendix.]

The CHAIRMAN. Thank you so much, Mr. Slavitt.

Let me just start with this. Of the 11 CO-OPs still in operation, there is reason to call their long-term financial viability into question. All but two of them are losing money. Not a single one of them had an underwriting gain through the third quarter of 2015.

As CO-OPs generally continue moving into weaker financial conditions, several show signs of running out of money this year. Yet, CMS certified these CO-OPs to sell in the Federal marketplace, putting those enrollees into the position of possibly losing their current plans later this year.

Now, the question I ask is, why would CMS certify these plans to sell on the Federal marketplace knowing that there is a good chance that these plans will fail and leave their enrollees in the lurch?

So that is a question I think a lot of us have.

Mr. SLAVITT. Thank you, Mr. Chairman. And, as you rightly point out and you pointed out in your opening remarks, there is no question that the challenge of building a business in the first few years, a small business competing against very large competitors, is indeed a big challenge.

Having said that, it does not surprise me that in the first couple of years, the CO-OPs are going to lose money. I think most small businesses competing in this space have those investment years.

So the States, I think, reviewed very carefully, with our assistance and our participation, whether or not the CO-OPs should indeed move forward into the coming year, and as a result, as you know, decisions were made to not allow certain CO-OPs to enter the year.

The ones that entered the year, the States—which are the ultimate regulatory authority, with our support—believed that these CO-OPs had the wherewithal to make it through the year, and I think they have taken actions to support that.

My final point I would add is, for the very reason you point out, I am eager to loosen up the capital rules so that we can get more capital into some of these CO-OPs and lengthen the runway, because I do want to make sure that they have every opportunity to succeed.

The CHAIRMAN. All right. There are several CO-OPs in receivership at the State level, as I understand it. State regulators work through the process of ensuring that outstanding claims are paid and consumers are protected.

There is a growing concern about Federal payments owed to the CO-OPs. Will the CO-OPs receive all re-insurance and risk adjustment payments due them for 2014 and 2015?

The second question would be, will they receive any tax credit or cost-sharing reduction payments that are owed after reconciliation?

Mr. SLAVITT. Thank you for your question. I think this topic of the collectability of the loans is one of the things that is a very high priority for us right now.

We clearly have a fiduciary responsibility to use every tool that we have, and by Treasury regulation, with the Department of Justice we are now working hand-in-hand on these collections to make sure that we maximize the returns.

To your specifics, I think there are three broad sources that we are looking at that are going to be a source of returned funds for taxpayers at the Federal level. The first is, as you point out, there are a series of receivables that some of these CO-OPs have. Second is, there are audit and legal actions that I think are appropriate in some cases that we are working with DOJ on. And third and finally, there will be cash in the CO-OPs themselves when they get through paying the providers and paying off claims, which, of course, as you say, will happen over the next several months through the receivership process.

The CHAIRMAN. Under most State laws, Mr. Slavitt, monies owed to the Federal Government are a low priority during the liquidation process.

Has CMS reviewed these laws, and does it believe that they are in any way preempted by Federal law?

Mr. SLAVITT. We are working closely with the Department of Justice, working through those very things very closely. I think the next several months, after some of the final claims come in, will be a time when the Department of Justice, in working with us, will clarify.

We have taken the first step of calling the loans, which we did in December, and then as a follow-up, we are working on a plan with the DOJ on exactly what the priority ought to be for us.

The CHAIRMAN. Thank you. Well, keep us up to speed on that.

Mr. SLAVITT. I certainly will.

The CHAIRMAN. One last question. Does CMS expect any of the remaining CO-OPs to close in 2016 during the benefit year, and how does it plan to assist the customers who will inevitably experience disruption in their health coverage?

Mr. SLAVITT. Thank you. We work hand-in-hand with the States on these matters, and currently I think all of the CO-OPs that have entered the 2016 plan year have every opportunity to be successful.

I think we have learned over the course of time that it is our job to try to anticipate problems rather than have them presented to us. So as soon as open enrollment ends, of course, we have a financial audit that will go on in each of the CO-OPs, and I am sure we will learn more. But each of the CO-OPs that is in business today, while it is a small business, certainly with its share of challenges, has every opportunity to be successful this year.

The CHAIRMAN. Thank you.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Slavitt, thank you for your responses to Chairman Hatch, because it indicated that you want to work in a proactive way to ad-

dress these issues, and that, to me, is a great challenge with respect to health care.

Those who have been critical of the Affordable Care Act spend hour after hour after hour talking about the problems, and what we have to do now is find a way to get some solutions. I suggested several paths for this committee on other issues, particularly chronic disease and challenges with respect to affording these wonderful cures for chronic diseases, and I want to do the same thing here with you on CO-OPs.

So you have been at this now for some time as Acting Administrator. What do you think needs to be done differently, specifically, from what was done at the outset so we can turn this around?

Mr. SLAVITT. Thank you. I want to respond to something you said in your opening comments, which is, we have great appreciation at CMS for the work that you and Senator Grassley have done on drug costs and innovation and how to make sure we get the best of both in this country, and it has been very helpful to us. So thank you, and thank the committee for that.

I think you are exactly right. I think our goal is to be proactive and to try to anticipate problems and challenges. And from our standpoint, the most important things we can do are, first, to make sure that the CO-OPs have opportunities where outside capital and the opportunity for mergers, if that is what they decide to do, are very much on the table so we can give the CO-OPs as much running room as possible.

Secondly, I think States have taken an active role, including this period. Two of the CO-OPs have had enrollment caps put in place, which is really an attempt to make sure that the size of those businesses stays consistent with the amount of capital they have, because they only have limited amounts of capital. It is a very proactive move, and we appreciate that.

Then finally, I think a lot of this today is very much in the hands of the CO-OP teams themselves. When I ran a small business, I focused very much on cash in the door and cash out the door. So from an operations standpoint, making sure that the products are priced right, that they are current on their claims, and all of those basics, I think will really serve them well.

Senator WYDEN. I indicated in my opening statement that I think part of this is the debate about startups generally, startups in America. Are there challenges that a new insurance company faces that might not be present in other industries?

Mr. SLAVITT. That is a really important point. I think about the challenges that the CO-OPs face every day, and, coming out of the gate, they probably have a 20- to 30-percent higher cost structure just because they do not have the negotiating leverage with the hospitals in their community.

They do not have the information that some of the bigger companies have to price their business, and, of course, they are working—they have to, by definition—with a series of vendors instead of having employees who know the business quite well.

So it is a big challenge. It is the reason why there are many States that have not had new entrants for decades. And remember, we are talking about a lot of money, $100 million or so, for a CO-OP, which sounds like a large company until we think about the

fact that they are competing with companies that have billions and billions of dollars in surplus.

So it becomes a very thin margin of error for a lot of these small businesses.

Senator WYDEN. Now, talk for a moment, if you would, about how these CO-OPs relate to the Affordable Care Act and the broader insurance market generally?

My sense is that competition is still strong in a great many marketplaces, with roughly as many new insurers entering the marketplace for 2016 as there are exiting. Is that correct, and could you give us some numbers so that we can really begin to get into the possibilities of looking at something that I think ought to have bipartisan support?

Back when I introduced the Healthy Americans Act, we had seven Democrats and seven Republicans. It was all about coming together around private insurance.

So tell me a little bit about the situation with respect to competition and the number of insurers entering the market relative to the number that are exiting for 2016, so we have the latest numbers.

Mr. SLAVITT. Sure. Competition is our friend here, because it not only makes prices affordable, it also allows consumers to get new innovations that companies offer.

You are exactly correct. The metric we look at, the most important metric for us, is what percentage of the American public has three or more insurance company options to choose from when they are making a health plan decision.

Senator WYDEN. Three or more private——

Mr. SLAVITT. Correct; three or more private insurance company options to choose from. Today, over 90 percent of Americans have over three or more options to choose from. So obviously, in the context of the CO-OP program, we think stimulating new competition is a really important idea, but I also think it is important for us to keep in mind that there are literally hundreds of companies with thousands of plans and, as you point out, some will come in, some will come out.

This will happen over the course of time. But most important is making sure consumers have choices.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Grassley?

Senator GRASSLEY. I will be somewhat repetitive, but I come from the experience of Iowa having the first CO-OP to go out of business. So by any objective account, CMS has failed in overseeing the CO-OP program; $2.5 billion in loans have been given to these 23 CO-OPs.

For the 12 that have failed, it adds up to $1.2 billion. In 2011, HHS predicted that only 65 percent of the solvency loans and 60 percent of the startup loans would be repaid. In 2012, OMB predicted taxpayers would lose over 40 percent of the loans offered through the program.

In 2013, we had an OIG audit warn that 11 of 16 CO-OPs were at risk of exhausting startup funding before they were fully operational. In 2015, another OIG audit warned that the low enroll-

ments and net losses in 13 of 23 CO-OPs might limit the ability to repay startup and solvency loans.

So I think you can see that we have good reason to be concerned about CMS's oversight role. I know a lot of this went on before you were there, obviously. But the warning signs were there.

So I said 1 year ago about Iowa—that CO-OP was called Co-Opportunity. Iowa and Nebraska entered into liquidation, like I said, 1 year ago. So it first failed in Iowa. The Iowa CO-OP was the second largest in the country, and when it failed, it left thousands of Iowans scrambling for health insurance.

My staff spoke to the Iowa insurance commissioner recently, and he reported that as of September 1st last year, all affected Iowans have other health insurance.

So for you, as an administrator now, my concern is, if one of the largest CO-OPs can fail, what about the rest? I have heard you talk positively about the future for those that are still in it.

In your testimony, you mentioned CMS is conducting site visits, collecting financial statements and other data. CMS was supposed to be doing all of those things, and yet, 12 CO-OPs failed.

So, going back to your testimony, you stated what additional measures you are taking to protect individuals enrolled in CO-OPs and to protect the taxpayers.

I think you made some reference to independent audits that are going on now. You might want to tell us about them, and then have actuaries reevaluate the program.

If you are taking steps like that, will you be sharing your findings with the committee?

Mr. SLAVITT. Thank you. I would like to start by spending a minute, if I could, on CoOpportunity, Senator, because, while it was a bit before I became Acting Administrator, it turned out to be a very important shaping event in how at least I thought we should be setting up and monitoring the CO-OPs proactively.

I think one of the things that we learned there is how quickly things can happen and how quickly things can deteriorate. I know that the team who was, at the time, granting CO-OP loans wished they could have funded every application that came in. They simply did not have the money.

But I think that certainly CoOpportunity wanted more money, reached out for more money, did not get it, given the shortage of funds, and then, between the second quarter and the third quarter, if I am not mistaken, CoOpportunity's loss tripled. So it happened rapidly.

The important lesson for us and for me was, first of all, as you pointed out, that the team members of the CoOpportunity plan—which had roughly 120,000 enrollees—focused full-time, in cooperation with your office and mostly with the department in Iowa, to make sure that those people got continued coverage, and, thankfully, as you have pointed out, virtually everybody whom we know of was able to find coverage.

But the other lesson that that taught us was that we have to be strategic at the end of a year, prior to the open enrollment period, so that a company does not end up getting into the situation that we had in Iowa and Nebraska, where, in the middle of the year, they fail.

So the reason that there were so many CO-OPs that closed at the end of last year was, we worked hand-in-hand very aggressively with the departments of insurance to make a full-on 12-month assessment. And even those CO-OPs that seemed like they were in pretty decent shape at the time, but did not have the wherewithal to last through the end of the year, the departments made, I think, very wise and prudent decisions to make sure that those did not continue.

I have to say that the enhanced oversight and the audits and all of the transparency we now require comes very much from that experience.

To your point about sharing documents with you, I believe this week and prior, we have turned about 1,000 new documents over to the committee on this topic. So we want to have complete transparency with you so you see exactly what we see.

Senator GRASSLEY. Thank you, Mr. Chairman.

Senator WYDEN [presiding]. Thank you, Senator Grassley.

Senator Toomey?

Senator TOOMEY. Thank you, Senator Wyden.

Administrator Slavitt, thanks for joining us today. Just very briefly, I want to touch on one matter that is off the topic today, if I could, and follow up on the very brief exchange you and I had prior to the hearing, which is the work that we can do together to address part of the problem that is contributing to this appalling tragedy of opioid addiction and heroin addiction and deaths from overdose.

I think everybody on this committee is painfully aware of this problem. I do not think a single one of us is from a State that is not affected by this.

Fortunately, I think there are a number of things we can do to help address this. The administration has consistently urged Congress to pass legislation that would give Medicare the same authority that Medicaid already has, that the private sector already uses, and I am referring to the authority to lock in certain beneficiaries, lock them into a single prescriber and a single pharmacy when it is determined that they are likely to be getting excessive quantities of opioids and perhaps diverting these to untoward uses.

I have a bill. Senator Brown is the lead Democrat on the bill. I want to thank Senators Casey and Portman from this committee who are also cosponsors of this legislation. And it would do just this: it would simply extend to Medicare the power that Medicaid has. It would take a significant step, I think, in the direction of diminishing the risk of diversion.

I want to ask you if CMS and the administration fully support this approach and if you would support enacting this legislation as soon as practical.

Mr. SLAVITT. Thank you, Senator. Thank you for your leadership on this very challenging issue.

I know, from work we have done with you and your office in western Pennsylvania, how personally involved you have been, and, of course, we are dealing with the effects of this every day as well.

We think that a lock-in proposal makes every bit of sense in the world, and we completely agree that that is the kind of authority

that would be very helpful in really taking a practical measure to stem abuse.

Senator TOOMEY. If I remember correctly, the President's budget has actually called for this policy.

Mr. SLAVITT. That is correct.

Senator TOOMEY. Is it your understanding that the President's upcoming budget is likely to renew that call?

Mr. SLAVITT. That is what I would expect, yes.

Senator TOOMEY. Well, I want to thank my colleagues on this committee who have joined in this effort, and I would really like to urge this committee to take up this legislation. It passed the House by a big bipartisan vote. It is bipartisan. It actually is scored to save money as opposed to cost taxpayer money, and it almost certainly would diminish the risk of addiction and death.

So I really, frankly, cannot think of too many higher priorities for this committee in the near term.

I want to bring up a different topic, and that is the Federal exchange.

Administrator Slavitt, the fact is, since it was created, the Federal exchange has lost money; is that correct?

Mr. SLAVITT. I am sorry?

Senator TOOMEY. The Federal exchange does not operate at break-even. The user fees that are generated from the tax on the premiums are not sufficient to cover the costs; is that correct?

Mr. SLAVITT. Actually, there are certain costs that we are not permitted to cover with user fees because they are considered inherently governmental functions.

Senator TOOMEY. My understanding is that the legislation requires that the user fees cover the costs of operating the exchange, but that, in fact, the user fees are covering only something on the order of 40 percent of the costs.

Mr. SLAVITT. I think my clarification would be that user fees are intended to cover certain costs of the exchange, but not all of the costs of the exchange. I cannot give you an exact number, but I believe it is closer to 60 percent to two-thirds of the costs that get covered with user fees. But I will get back to you with a more precise number.

Senator TOOMEY. My understanding is that CMS officials have suggested that they believe that the user fees will fully cover the costs of the exchange by 2017. So, if they are not permitted to cover the full costs of the exchange, why are we projecting that they will be?

Mr. SLAVITT. Maybe it is a definitional item. There are costs that we incur to operate the exchange that, by law, user fees are not permitted to cover; but, not counting those, maybe that is where your analysis——

Senator TOOMEY. Well, I see I am out of time, but I would be very grateful if you would follow up with an answer to basically this question. To what extent are the user fees appropriately designed so that they cover all of the expenses they are supposed to cover?

Now, my understanding is that they are falling short, that the user fees are set at a level that is not adequate to cover those costs. But if you could clarify that, I would be appreciative.

Mr. SLAVITT. We will clarify that, Senator. Thank you.

Senator TOOMEY. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Casey?

Senator CASEY. Thank you, Mr. Chairman.

Administrator Slavitt, I appreciate you being here and appreciate your work, your public service.

I would start by saying that I think Senator Toomey is right on two things: number one, that this opioid problem is a matter of great urgency; and number two, that there is a bipartisan consensus to confront the problem and propose solutions. I know this committee is prepared to do that.

My question really focuses on the broader question of the challenges you face with CO-OPs, and I guess I would start with the predicate that when I look at what the Congress can do over the next number of years, when we debate the ACA and debate changes to it, you can join kind of one of three caucuses, right? This is my view of it.

Caucus number one is the "it is perfect, do not touch it" caucus. That is probably not reasonable. No law that deals with a subject as complex as health care can be perfect upon enactment. I wish it were so, but I do not think that is the case.

The other caucus on the other extreme is what I call the "repeal and walk away" caucus. Unfortunately, I think there are some members of that caucus in Washington. I do not know how many. But that does not make sense.

So we know it is not perfect, but we also cannot walk away from the problem, as some seem to want to do.

The third caucus, I think, is the best caucus or the best point of view and the best perspective on this, which is, let us fix problems in the ACA in a bipartisan fashion and make sure we do not undermine or destroy the achievements.

There are 17.5 million people, more than 17.5 million now, who have health care today who would not have it, would not have health-care coverage absent the ACA, which helps all of us, because now you have millions of people who are not using the emergency rooms as their primary care doc and having the rest of us pay 1,000 bucks a head to pay for that care.

Secondly, we are implementing and making normal or routine things that used to be exceptional and rare—making sure we are reducing hospital readmissions, for example, which leads to better health outcomes for the individual, better results for the hospital, and saves a heck of a lot of money.

So I think there are lots of areas where we can fix a problem and improve the law.

I guess stepping back—and this is really the only question I have—when you look down the road, in light of these challenges that we know we have, how do you view CO-OPs in terms of how they fit into an overall vision for the private health insurance market?

Mr. SLAVITT. Thank you, Senator Casey. That vision you laid out of rolling up our sleeves and really examining in a self-critical matter what is wrong and trying to fix it is exactly what I am trying to bring into the agency, and I would say it is what the agency very

much tries to do, which is to make sure that in the first few years of this law, we are doing things to make it better.

I had the honor of being Acting Administrator during the 50th year of Medicare and Medicaid, and those programs which mean so much to so many people also had a 3rd year and a 4th year and a 5th year, and I often think about what the people who were working here at that time were working through.

I think CO-OPs are a part of the overall package aimed really at stimulating competition in an industry where it is very hard historically for new competitors to enter.

So to your point, I do not think it is reasonable to expect—and I do not think anyone expects—that the way it was designed was necessarily perfect coming out of the gate, but we need to do everything we can to make it easier for these companies to succeed and ultimately for taxpayers to get paid back on the loans that we made to these companies.

I think the one thing I would put forward today is making attracting outside capital or a merger partner a much more easy and readily available thing for these small businesses, because every other small business in America is able to raise capital, and we need to make it easier for them as well.

Senator CASEY. Great. Thanks very much.

The CHAIRMAN. Thank you, Senator Casey.

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman.

I want to shift gears for just a minute and ask a couple of questions on a couple of issues that are important to my State.

Over the last few weeks, I have grown encouraged, Mr. Slavitt, by your recent statements pertaining to the meaningful use program. I think as you know, Senator Alexander and I wrote to Secretary Burwell last year requesting that the administration delay implementation of meaningful use stage three. Instead, we encouraged the program to phase in stage three requirements at a rate that reflects how successfully the program is being implemented.

As we look toward the future of physician reimbursement, now is the time to finally align the various requirements that we place on our physicians. So in my opinion, I believe that CMS should pause stage three and engage with stakeholders over the next year to better align stage three requirements with the implementation of the Merit-Based Incentive Payment System, or MIPS. By doing this, CMS could ensure that the final stage of the meaningful use program is meaningful to providers as we continue to move toward MIPS implementation.

So, in light of your recent blog post, I am wondering if CMS is now considering such delay. Additionally, could you discuss CMS's current plans for aligning these programs?

Mr. SLAVITT. Thank you for the question. Really at the heart of your question is an important acknowledgment. We have to do better by the caregivers and patients in this country by taking on what we have learned and what physicians all over the country are saying.

We do not want to pay physicians to become computer operators. We want them to be caregivers, and we want technology companies to build tools for them to make that easier.

So we have a regime, as you point out, that has been part of the statute, and we were given, I think, a terrific opportunity with the passage of the MACRA legislation to step back and take stock of really where we are and what we want out of technology, and that opportunity is really to move from a situation where we are rewarding people to use their computer to where we are rewarding people to get the best outcomes for their patients and for their populations using technology as an aid.

That will, of course, as you point out, put technology companies back in the business of doing work for their customers again instead of simply meeting regulations.

So we are going through the process now of working through the details. I think we have a very, very busy few months ahead of us to get that right. We are hearing from and inviting everybody, whether they are physicians, patients, or technologists, to come in and talk with us, and then we will put out a proposed rule, of course, in the next several months that people will have a chance to react to.

I think our commitment needs to be making it better and better and better and making things simpler and simpler and simpler. That has to be our direction.

Senator THUNE. Are you considering a delay?

Mr. SLAVITT. I think that the impact of what we do with MACRA—and again, I want to be thoughtful about not speaking about a regulation before I am supposed to so I do not get out of line, but I think you will feel the effect and people will feel the effect of what we do with MACRA to accomplish the aims that you, Senator Alexander, and others, and, most importantly, the physicians in this community, have been pushing for to remove some of the burden that people feel coming with meaningful use.

The other thing I would point out is, for any physician, you have given us now more flexibility and authority to grant hardship exemptions to physicians so that we are not needlessly penalizing small docs who are really just trying to take care of their patients.

So I think there is very positive momentum, and I think as the details come out, I am hoping you will be very pleased.

Senator THUNE. As you know, some of the other members of this committee and I are closely watching the effects of the rollout of the competitive bidding program for durable medical equipment and the impact that it will have on beneficiary access.

Ensuring that seniors have access to this equipment really is vital to ensuring that they may remain in their homes. In 2014, CMS released its final rule relating to the national rollout and stated, and I want to quote, “CMS will monitor access and health outcomes using real-time claims data and analysis,” without any further explanation.

So I have a two-part question. One, can you explain how CMS is monitoring the national rollout to ensure beneficiaries still have access to this equipment, and two, would you consider extending the current phase-in beyond July 1st?

Mr. SLAVITT. I think there has been some legislation which has helped us in that arena to do this, but I think at the heart of your question—I want to talk about two things.

One is, we have to watch the effect of everything we do not just on the average population, but on the very specific communities where sometimes health care is hardest to obtain. As you rightly point out, we have to do, and we do now as a matter of protocol, a real impact analysis on all of these things.

The way we have to roll these out thoughtfully is by doing it in stages and measuring the impact and taking in feedback, and we have the absolute authority, if we see access issues, to step in and prevent them.

So we cannot let the goals of this program, which are noble and I think good for our budget, get in the way of common sense when we run into those issues.

So we have been, hopefully, responsive along the way, and we will continue to do that.

Senator THUNE. Do you think 6 months is enough?

Mr. SLAVITT. I think that is exactly what we should be testing right now. I think we should not assume that 6 months is going to be enough until we work through it.

So, candidly, I want to see the data from our team that is conducting the data monitoring and understand the impact, and if we believe that we are going too fast, we will slow down.

Senator THUNE. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman. I very much appreciate this hearing.

Mr. Slavitt, first of all, thank you very much for your service and all your hard work to ensure the success of the Affordable Care Act. It is very much appreciated by people in Maryland and this country.

I want to talk about a CO-OP that is in Maryland, because it is truly unique: Evergreen Health Cooperative. It has been a leader in innovation in Maryland's health insurance marketplace.

It is unique in that it operates a tightly affiliated, nonprofit organization of primary care offices—so it provides the direct services—which offers state-of-the-art, comprehensive, patient-centered care, including health coaches, wellness centers, behavioral health, primary care, and care coordination onsite.

While we all talk about how we can improve the way we actually deliver health care, they are doing it. They are not just a payer of services. They are a provider of what we are trying to get done, and it is the diversity that we wanted in the Affordable Care Act as regards patient choice.

So close to 6,000 Evergreen members use the center as their primary care provider. I can give you an example where they designed a unique protocol for patients with diabetes so that they can get all the different components covered, from pediatric care to primary care visits, eye checks, et cetera.

So here is the problem. They look at the risk adjustor as hopefully helping, but like most of the CO-OPs, I think all but two, the result of the risk adjustors is they actually have to give up money—they pay money.

I am not a technician. I do not understand all of the aspects or the pluses and minuses, and I will be glad to become better in-

formed about that, but I do know that there is a difference between a relatively small operation and a large operation which has been in existence for a long period of time, where they can have a better opportunity to reflect on the risk adjustor issues, whereas the small operator may not have those same opportunities.

The full implementation of that negative impact on Evergreen would be devastating. So we have been looking at whether there are any ways—I know you are looking at adjustments in the risk adjustor issues that go through the normal rules process, but one suggestion that has been made is to have a 2-percent ceiling on the amount that they would have to pay, because the percentage, I have been told, in Evergreen is a huge part of their annual premium budget. I think it is like 15 percent, which is just not manageable.

Could you just share with us whether ideas like this could be worked into the risk adjustor so that the small CO-OPs can have a more predictable life and, therefore, have a better chance of succeeding in a very competitive marketplace?

Mr. SLAVITT. Thank you, Senator. If I might, Evergreen is, from what I know about it, exactly the kind of example of the kind of competition and the kind of innovation that unique, small companies can provide that I believe the CO-OP legislation was hoping for, and we certainly understand the challenges that they face.

I believe, if I am not mistaken, that they may be the first new entrant in the State of Maryland in some time, maybe 20 years or so. So it is an enormous challenge for them.

And in respect to the risk adjustment process, which is what you have asked about—and I might say that the risk adjustment process is what allows insurance companies to take on sicker people. So it is very, very important.

In a world where we do not want people to be prohibited from getting insurance because they have a preexisting condition or they may be sick, it is very important that people who take on sicker people can get fairly compensated for them.

It is very important because, in fact, as you point out, the people with sicker populations take in money, the people with healthier populations pay out money. The government actually just sets the rules. We do not know where the money goes, into the government coffers or out of the government coffers. That those rules are known by folks in advance and that they are predictable is important so people are playing by the same sets of rules.

So it is very, very important, as we look at a process which works today, that we find opportunities to make it better, that we do it in a way where all the participants can participate in it, and that we do not change the rules on people after the game has been played.

So we have, I think, announced a session where we are having all of the participants in the market, the CO-OPs and otherwise, come in and provide ideas. We think there may be opportunities to make the risk adjustment process better along the way, as has happened in Medicare and in other places, and we are very much looking forward to supporting Evergreen as it continues its growth.

Senator CARDIN. I thank you for that. I would just make one final observation. If you were to observe the target population that

is in Evergreen, you would know that they are certainly taking all comers, and they are encouraging the widest possible group, including those at high risk. So it was somewhat counterintuitive that there would be such a large negative for them.

I would just ask CMS to look at some type of a circuit-breaker so that they can at least put into their financial projections a manageable number as they look to the future viability of the program.

Mr. SLAVITT. Sure. Thank you, Senator.

The CHAIRMAN. Thank you, Senator.

The vote started 16 minutes ago.

Did you vote, Senator Portman? You are next.

Senator PORTMAN. I have not voted, Mr. Chairman. I am willing to take a risk to be late for the vote.

The CHAIRMAN. Well, I am going to take off, and I will tell them. I will try to get them to hold.

Senator PORTMAN. They said they would hold it open for a while. I do not want to miss my opportunity to have a dialogue.

Senator WYDEN [presiding]. You are on.

Senator PORTMAN. Thank you, Senator Wyden.

First, I appreciate your testimony this morning, Mr. Slavitt. Thanks for all your information. With regard to the lock-in program, this is critically important for Ohio and other States right now.

We have, as you know, this heroin epidemic. On average, we are losing 20 people a week in Ohio to opiate overdoses. Most of it is now heroin, but most of it started with prescription drug abuse.

So what we are trying to do is simply make it harder for people to be overprescribed, both because we do not want them to be able to sell those pills on the street, which happens, but more importantly, so that they themselves do not become addicted through this over-prescription, and one way to do that is to lock in under Medicaid as we do under Medicare.

So this is part of a much broader answer. We have legislation, the Comprehensive Addiction Recovery Act, which we are also trying to move. But I thank you today for your stated support of this legislation, and I urge the committee to move forward on marking this legislation up.

With regard to the CO-OPs, I have lots of questions, and I guess the key for me is, how could this have happened and what can we learn from it?

As I look at it, it is a program failure. It has wasted up to $1.2 billion now in taxpayer money. I heard you say earlier you thought some of that money might be recouped. I would make the point that, to my view, none of it has been recouped—zero.

These are failed enterprises. So I think saying $1.2 billion has been wasted is probably accurate. That is enough, by the way, to pay for health care premiums for more than 300,000 Ohio families in 1 year.

It is our job to be the oversight committee here and to find out what the heck happened and how could it have happened, particularly under the purview of HHS.

I think we could have protected taxpayers better, we could have protected these patients better, many of whom were finding themselves without any coverage because their CO-OPs failed.

Instead of cancelling loans or reducing loans to deal with these failing CO-OPs, as I look at it, HHS actually accelerated so-called solvency loan payments for these failing CO-OPs. Some of this may have happened before your time, some after your time, but the point is that HHS, in my view, did not provide adequate stewardship over these CO-OPs.

Let me clarify a point in your testimony. I read that you say that 85 percent of the $2.5 billion in CO-OP loan funding was awarded—and this is a quote—"before coverage began in January 2014."

I do not think that is true. I believe it is true that more than half of that $1.2 billion in taxpayer-backed loans received by the failing CO-OPs we talked about, the $1.2 billion that I would argue is essentially wasted taxpayer money, was actually disbursed after January 2014.

Would you like to comment on that?

Mr. SLAVITT. I want to make sure I get your words correct. There may be a difference between "awarded" and "disbursed," but the loan awards, in order to have enough capital for the CO-OPs to enter the markets—and, as you would say, this was a little bit before my time—as you say, 85 percent of the loans were granted, and then they were disbursed on a schedule to move the capital as soon as the CO-OPs needed it to support the business that they had written.

Senator PORTMAN. I think if you look at the public financial statements of these CO-OPs, you will see a different answer, which is, again, that more than half of the $1.2 billion that was loaned to CO-OPs that have failed was actually received by these CO-OPs after that 2014 date.

I would encourage you to look at those financial statements. They are public.

Throughout 2014, HHS was writing a series of multi-million-dollar checks to the CO-OPs. As they were doing that, exactly what financial indicators did HHS review to make sure that each loan disbursement continued to be a sound investment? What were you looking at?

Mr. SLAVITT. Again, I think we probably want to get together to make sure we are looking at the same sets of numbers, but I think there were approximately 15 percent of the loans that were granted during the course of 2014, again, before I became Acting Administrator. So I am a little bit tracing history here.

But I have looked at the paperwork and the documentation, regardless of what the number is, that the companies went through—and they were very extensive applications, required third-party review, required in-depth evaluation. While it was not the largest portion of the funds that went out, these were funds that went out at a time when the solvency needs were really, I think, driven by the size of the business.

The other thing I would point out is, Senator Portman, in focusing on the people who were making the decisions at that time in 2014, this was, obviously, before there was even a full year of financials, and given the way, of course, that claims work in the insurance industry, there was a very limited amount of claims information to work from.

So I think that the decisions were made with the best information that folks had. I would say it was not until the first and second quarter of 2015 that at least I felt we started to have a really good picture of——

Senator PORTMAN. If I could interrupt you for a moment, because my time is expiring and we have a vote on, as you know.

In addition to that, let me just say this. There were monthly reports concerning enrollment, net income, and medical loss that were available to you. These are publicly available documents.

They show that not just every single one of those CO-OPs that failed was losing money. All of them were losing money. This was while you were providing this taxpayer money to these entities. They also show that they had dangerously high medical loss ratios.

So you are saying we needed to wait. There was no good information; it was all negative. So I think these are the kind of financial red flags that any prudent regulator would have looked at, and I think HHS blew it.

So I do not have time to go into further detail now. I would love to get together and talk more about this. As you know, we are doing a more in-depth investigation of this issue. But the point is to avoid, going forward, losing this kind of taxpayer money and, also, having the very real issue of these patients losing coverage.

Ohio, probably to our benefit, has looked back on its status quo. In that first year, we could not get approvals, and, as a result, we only got about 15 percent of the enrollment that we expected. As a result, we are not in as bad a shape.

Mr. SLAVITT. Right.

Senator PORTMAN. But these other CO-OPs, I think this was terrible management, and I think we need to ensure that we have better management going forward, and I think we need to look carefully at what happened and why.

Thank you, Mr. Chairman.

Senator WYDEN. Thank you, Senator Portman.

Chairman Hatch had to leave. He has a lot of responsibilities this morning. He has a statement that I want entered into the record, by unanimous consent. I also want to remind members about making sure that they get their questions in promptly.

Mr. Slavitt, you have done, in my view—this is just my opinion—I think you have done very well, and I think you have shown, again, why you would be a very good choice to be the permanent Administrator. So I am going to do everything I can to try to move that along as well.

I am just going to wrap up with a couple of thoughts. This is the first hearing, the first health-care hearing of 2016, and the popular wisdom, of course, is that you cannot tackle major issues in an election year. I mean, you just hear that—if I had a nickel for every time I heard somebody on cable news say you cannot do anything big in an election year, you could take care of your kids' education. This is just kind of the popular wisdom.

I do not buy that, and I will let Chairman Hatch speak for himself, but I know he very much wants this committee to work in a bipartisan way. That is what we are doing with respect to the chronic disease issue.

I happen to think both political parties missed that during the Affordable Care Act debate. I went back and reviewed virtually all of the discussions, and there was very little mention of what is going to drive Medicare for decades to come.

This committee now has begun to work in a bipartisan way. We are very much interested in a bipartisan chronic care bill.

I think we also heard this morning from Senators who have a great interest in the issue of opioids—and you can debate the various merits of a particular bill. My State has one of the highest rates of opioid abuse incidents. So we are very, very concerned about it, and I do not think there is anything partisan about that.

So my hope is that we can tackle big questions. I mentioned the work that Senator Grassley joined me on. We reviewed essentially 20,000 pages of various kinds of e-mails and documents and the like, and I came away with the concern that we are going to have all these blockbuster drugs in the future, spectacular cures for illnesses, and the question is, will people be able to afford them? Based on what we saw with respect to the blockbuster hepatitis C drugs—and these are cures—this is a dramatic, dramatic change in health policy, and yet only a fraction of the people can get them.

My concern is, most people will not get them until it is very late, and then they will have suffered very significantly from a health standpoint, and their care will cost even more.

So I think you have given us today the kind of responsiveness that makes it clear that CMS wants to work with Republicans and Democrats alike on this committee. I will do my best to see you confirmed, and, to me, I think the important thing to be reflecting on this morning is turning the popular wisdom of an election year on its head, not sitting it out, not saying it is impossible to do anything, but to do what Chairman Hatch and I have been talking about, which is to say, this is a committee that really leads in terms of trying to come up with bipartisan approaches to major challenges. We appreciate your cooperation.

With that, the Finance Committee is adjourned.

[Whereupon, at 10:48 a.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

Prepared Statement of Hon. Orrin G. Hatch, a U.S. Senator From Utah

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R–Utah) today delivered the following opening statement at a hearing examining the management failures of Obamacare's Consumer Operated and Oriented Plans (CO-OPs) and its impact on consumers, patients and taxpayers:

I'd like to welcome everyone to this morning's hearing on financial and oversight controls for health care CO-OPs.

Six years ago, the so-called Affordable Care Act was forced through Congress and signed by President Obama. The law was passed on a series of strictly partisan votes over the opposition of the majority of the American people.

At that time, supporters of the law claimed it would both expand health coverage and bring down costs. Not surprisingly, as the health law has been implemented, reality has had a different story to tell.

Under the Affordable Care Act, millions of Americans learned the hard way that—despite many promises to the contrary—they could not keep their previous health care plans, even if they liked them.

Under the Affordable Care Act, health insurers, unable to sustain the losses resulting from the law's draconian mandates and regulations, are dropping out of exchanges across the country.

Under the Affordable Care Act, insurance premiums are rising—at astronomical rates in some parts of the country—and options for patients and consumers are decreasing, seemingly by the day.

And, under the Affordable Care Act, the so-called Consumer Operated and Oriented Plans are failing left and right. These Consumer Operated and Oriented Plans—or CO-OPs—are the subject of today's hearing.

CO-OP program was designed to encourage the development of a non-profit health insurance sector, which, according to its proponents, was supposed to improve coverage, increase competition, and provide more affordable health care options.

But, as with many other parts of the health law, reality has told a different story with regard to the CO-OP program.

Taxpayers have been forced to foot the bill for the CO-OP experiment, to the tune of $2.4 billion in federal loans for 23 CO-OPs around the country. And, to date, more than half of the CO-OPs have failed, while the vast majority of the others are in poor financial shape.

As a result, hundreds of thousands of Americans have lost or will lose their health insurance and taxpayers are still on the hook.

In some ways, the CO-OPs were doomed to fail from the outset.

For example, they were limited to less profitable markets, had no historical claims data, and had no brand recognition or trust. Some were established and run with political aims in mind, rather than solvency or efficiency. Several had premium prices that were far below that of their competitors, and, not surprisingly, they in-

curred costs that far outpaced revenue. Standard and Poor's aptly described establishing a CO-OP as "learning to ride a bike without training wheels."

There are a number of questions we could ask about the CO-OP program.

Why was it designed so poorly?

Why weren't there more safeguards in place to protect taxpayer investments?

Of course, many of these questions should be directed at those who actually wrote and passed the health law in the first place, none of whom will be testifying in this hearing.

However, today we will hear from Andy Slavitt, the Acting Administrator of the Centers for Medicare and Medicaid Services, which oversees the CO-OP program.

From a congressional oversight perspective, the main question we have today is: How has CMS dealt with these problems?

As it turns out, we know at least part of the answer. CMS has apparently encouraged the CO-OPs to cook their books with some creative accounting.

Last year, the agency issued guidance allowing CO-OPs to apply surplus notes to program start-up loans, which essentially allowed the CO-OPs to record loans as assets in their financial filings.

Quite honestly, I think I'm being generous when I call that kind of accounting "creative." Yet it is, as far as we know, now the standard of practice among Obamacare CO-OPs.

Today, I want to hear more about these types of creative ideas coming from CMS, because I believe the taxpayers deserve some explanation. Particularly those taxpayers who lost their coverage when the CO-OPs they enrolled in were not financially viable enough to provide them with the coverage they were promised.

Mr. Slavitt, you currently oversee an agency that is responsible for paying out well over $1.1 trillion through Medicare and Medicaid each year—a number that, by the way, will only go up in the coming years. While the CO-OP program is a relatively small drop in that bucket, it is still a significant investment on the part of American taxpayers.

I look forward to hearing your explanation of what's going on with this program and your ideas about what can be done to improve the situation.

PREPARED STATEMENT OF ANDY SLAVITT, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for the invitation to discuss the Consumer Operated and Oriented Plan (CO-OP) program. The Centers for Medicare and Medicaid Services (CMS) is committed to overseeing the CO-OP program and is hard at work providing CO-OP consumers and taxpayers important protections as CO-OPs expand access, choice, and competition, helping Americans access high quality, affordable health insurance coverage.

CMS's priority is to provide Marketplace customers with access to quality, affordable coverage. In the years since the passage of the Affordable Care Act, we have seen increased competition among health plans and more choices for consumers.[1] With the third Marketplace Open Enrollment underway, 9 out of 10 returning customers are able to choose from three or more issuers for 2016 coverage, up from 7 in 10 in 2014.[2] The CO-OPs have played an important role in the Marketplace, particularly in the early years of the Affordable Care Act by providing additional options for access to affordable health coverage from local, non-profit health insurers.

Moving forward, CMS is eager to build on the progress in reducing the number of uninsured Americans—an estimated 17.6 million Americans gained coverage since the Affordable Care Act's coverage provisions have taken effect,[3] and the Nation's

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[1] *www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html.*

[2] *www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html.*

[3] *http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-september-2015.*

uninsured rate is below 10 percent for the first time since data collection began over five decades ago.[4, 5] Through December 26th, 11.3 million[6] Americans have already used the Marketplace to select a plan or have continued coverage for 2016.

CMS IMPLEMENTATION OF THE CO-OP PROGRAM

Section 1322 of the Affordable Care Act established the CO-OP Program to foster the creation of non-profit health insurance issuers to give more choices and control to consumers, promote local competition, and improve diversity in the health insurance market. To this end, the law provided funding for loans to eligible entities to help establish and maintain these new plans. The funding initially provided by the law was intended to provide capital sufficient to support start-up costs, such as establishing provider network relationships, claims and financial operations, developing products, and meeting regulatory surplus requirements through the initial phase of operations. In implementing the CO-OP Program as required by statute and with the funds available, CMS evaluated loan applications, monitors financial performance, conducts financial and operational oversight, and supports state departments of insurance (DOIs), which are the primary regulators of insurance issuers in the States.

CMS established the CO-OP Program as outlined in the CO-OP Program Funding Opportunity Announcement[7] and the CO-OP Program Final Rule.[8] The framework for implementing the CO-OP Program was based on a report submitted by a Federal Advisory Committee appointed by the Government Accountability Office (GAO) under section 1322(a)(3) of the Affordable Care Act to advise the Secretary of Health and Human Services (HHS) regarding the award of CO-OP loans. The report included recommendations on governance, finance, infrastructure, criteria, process, and compliance for CO-OPs and a timeline for the CO-OP Program.[9] This report guided the major elements of how CO-OPs were selected, awarded loans, and monitored.

The CO-OP application review process was rigorous, objective, and conducted with input and expertise from an independent party, Deloitte Consulting, LLP. Deloitte used a team of insurance experts, actuaries, former state insurance regulators, and other experts to verify eligibility and evaluate each element of the application, such as the business plan, financial projections, and a feasibility study, using the criteria established in the Funding Opportunity Announcement. The Deloitte findings and recommendations were then sent to the internal CMS review committee, which was led by insurance experts and an actuary who was not on the CO-OP program staff. A July 2013 HHS Office of Inspector General (OIG) Report found that "CMS established a prospective oversight system to safeguard CO-OP funding and ensure timely implementation of the program."[10]

Of 147 applications,[11] 24 were selected to receive loan funds and ultimately entered into CO-OP loan agreements with CMS. Ultimately, CMS awarded $2.5 billion in loan funding to the 24 CO-OPs, over $2.1 billion, or 85 percent, of which was awarded before coverage began on January 1, 2014. The Federal Advisory Group emphasized the importance of awarding the funds "as expeditiously as possible" in order for CO-OPs to be able to compete in the 2014 Open Enrollment period.[12] As the statute required, loans were made in two forms:[13] start-up loans and solvency loans. Start-up loan obligations were specific to each CO-OP in an amount based on estimated costs of particular start-up activities. A disbursement schedule that governed the basis, timing, and amount of sequential disbursements of start-up loan funding was incorporated into each CO-OP borrower's loan agreement.

[4] *http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201508.pdf.*
[5] *http://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf.*
[6] *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-12-30.html.*
[7] *https://www.cms.gov/CCIIO/Resources/Funding-Opportunities/Downloads/final_premium_review_grant_solicitation_with_disclosure_statement.pdf.*
[8] *https://www.gpo.gov/fdsys/pkg/FR-2011-12-13/pdf/2011-31864.pdf.*
[9] *https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf.*
[10] *http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf.*
[11] Including 34 applications that were not subject to a full review process, but were subsequently denied due to funding rescissions.
[12] *https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf.*
[13] Sec. 1322(b) the Affordable Care Act.

As set forth in the statute, solvency loan funds assisted loan recipients with meeting regulatory capital and surplus requirements of the State(s) in which they are licensed, as well as additional CMS CO-OP Program requirements. CO-OPs requested disbursements of solvency loan funding to maintain state and CO-OP loan agreement required solvency levels. Solvency loan award levels were made based on the particular business plan included in the loan agreement and State regulatory capital requirements.

After the start of coverage on January 1, 2014, CMS awarded additional solvency funding to several existing CO-OPs. In making subsequent loan decisions, CMS undertook a rigorous review process substantially similar to what was conducted for the initial round of loans. This included both an external and internal review of updated business plans, feasibility studies, programmatic and regulatory compliance, actuarial soundness, and financial statements. Requests were made for more funding than was available, so the comparative level of need was also an important factor. The applications included actuarially certified analysis and financial projections, which incorporated data regarding the current and projected level of enrollment. During 2014, CMS provided approximately $352.5 million in additional solvency loan funding.

CMS used information available after the first round of funding about the size of enrollment and operational compliance to evaluate applications for additional loan funding. The enrollment, claims, and financial data available during the review of applications for both the first and second rounds of opportunity for additional solvency loan funding was limited in scope because these CO-OPs were in their initial stages of operation, and a substantial number of CO-OP members enrolled on or after the January 1, 2014 coverage start date. The late enrollment and the length of time it takes to receive, process, and pay claims and for those claims to have actuarial meaning, meant that at that time, CO-OPs had 6 to 9 months of enrollment data and claims experience for Deloitte and CMS to review.

While the Affordable Care Act appropriated $6 billion for the program, the Congress made a number of substantial rescissions to that initial funding level. The Department of Defense and Full Year Continuing Appropriations Act, 2011, rescinded $2.2 billion; the Consolidated Appropriations Act, 2012, rescinded an additional $400 million; and the American Taxpayer Relief Act of 2012 further reduced the remaining $3.4 billion of CO-OP funding by rescinding 90 percent of funds unobligated as of the date of enactment. Finally, an additional $13 million was reduced due to sequester in Fiscal Year 2013. The remaining balance was assigned to a new contingency fund available for oversight and assistance to the existing CO-OP loan recipients.

CO-OP ACCOMPLISHMENTS AND CHALLENGES

CO-OPs have provided health insurance coverage to more than 1 million consumers, helping people access needed medical care. This program has increased competition and provided more consumer choices and control in choosing health insurance coverage. For example, Maryland's CO-OP (Evergreen Health) was the first new issuer to enter the state's market in 25 years,[14] and New Jersey's CO-OP (Health Republic of New Jersey) was the first new issuer to enter the state's market in 19 years.[15] In Maine, the CO-OP (Maine Community Health Options) was one of two issuers on the Exchange in 2014; that year, it enrolled 83 percent of individuals who used the Marketplace to sign up for coverage. The CO-OP began offering coverage to the residents of New Hampshire in 2015.[16] Overall, CO-OPs have added both choice and affordability to health insurance coverage options available to consumers.

CO-OPs are also introducing local innovation. Ohio's CO-OP (InHealth Mutual) offers a disease management program for six different conditions that includes education, case management, and no copays for any visit, prescription, or supplies associated with management of the disease.[17] New Jersey's CO-OP (Health Republic of New Jersey) implemented a harm reduction program to help enrollees quit and re-

[14] *http://www.nytimes.com/2015/09/16/business/health-cooperatives-find-the-going-tough.html?_r=0.*

[15] *http://docs.house.gov/meetings/IF/IF02/20151105/104146/HHRG-114-IF02-Wstate-MorrisonJ-20151105.pdf.*

[16] *http://www.pressherald.com/2014/09/30/maine-insurance-co-operative-accelerates-plans-to-cover-new-hampshire/.*

[17] *http://www.inhealthohio.org/shop-for-insurance/individuals-and-families/2016-enrollment-material-individual-family-benefits.*

duce smoking.[18] CMS will continue our work to support CO-OPs as they pursue innovative approaches to coverage.

However, new entrants to any market, especially the insurance market, face numerous pressures and must overcome multiple barriers, particularly in their early stages of operations. In its July 2013 report, HHS OIG found that "the extent to which any particular CO-OP can achieve program goals and remain financially viable depends on a number of unpredictable factors. These factors include the CO-OP's State's Exchange operations, the number of people who enroll in the CO-OP and their medical costs, and the way in which competing plans will affect the CO-OP's market share."[19] CO-OPs entered the health insurance market facing a variety of challenges, including building a provider network and customer support, no previous claims experience on which to base pricing, and competition from larger, experienced issuers. The Federal Advisory Group found that many of the challenges the CO-OPs faced were the same as any new health insurance entity.[20] The Commonwealth Fund published a report on the factors that contributed to the CO-OPs' challenges, which provided further evidence of the issues faced by new entrants into the market, including having to outsource important functions, in particular network contracting, limited information about existing provider practices and referral habits, and initial enrollment that diverged from expectations.[21]

CMS OVERSIGHT

CMS has obligations to operate as a proper steward of the taxpayer dollars issued through the loan program and to administer the CO-OP Program for the benefit of consumers. Since awarding both start-up and solvency loans, CMS has been closely monitoring and evaluating the CO-OPs to assess performance and compliance, and has engaged regularly with State DOIs, which are the primary regulators of insurance issuers in the States. Twelve CO-OPs are no longer selling coverage in the Marketplace and are in various stages of winding down operations. The remaining 11 CO-OPs, serving 13 States, are being monitored closely.

CMS's oversight approach, informed by recommendations from both HHS OIG and GAO, consists of four parts. First, all CO-OPs are subject to standardized, ongoing reporting to and interactions with CMS that include weekly, biweekly, or monthly calls to monitor goals and challenges; periodic on-site visits; performance and financial auditing; and monthly, quarterly, semi-annual, and annual reporting obligations. Since March 2015, CMS has conducted site visits of CO-OPs in 15 states. We believe these visits are a benefit to plans, consumers, and taxpayers. These visits provide CMS with an opportunity to verify whether and how a CO-OP meets its obligations. During these visits, CMS reviews management structure and staffing, financial status, business strategy, the policies and procedures of the CO-OP, marketing and sales information, and operations, including vendor management and oversight. CMS also reviews whether a CO-OP is meeting their obligations for medical management and member relations. CMS also collaborates with DOIs concerning each CO-OP loan recipient.

Second, CMS monitors the CO-OPs' overall financial condition using several factors of the Federal Deposit Insurance Corporation's Uniform Financial Institutions Rating System. CO-OPs have monthly, semi-annual, and annual reporting requirements, including financial statements, balance sheets, income statements, statements of cash flow, and enrollment statistics. Last year, CMS increased the data and financial reporting requirements for CO-OPs. Each CO-OP is required to provide a semi-annual statement of its compliance with all relevant State licensure requirements, and, if necessary, an explanation of any deficiencies, warnings, additional oversight, or any other adverse action or determination by DOIs received by the CO-OP. If the CO-OP is experiencing compliance issues with State regulators, the CO-OP is required to describe the steps being taken to resolve those issues. CMS meets monthly with the state insurance regulators regarding each CO-OP. This additional financial data collection has helped CMS to identify underperforming CO-OPs and gives CMS the opportunity to work with the CO-OPs and DOIs to help correct issues that are identified.

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[18] *https://newjersey.healthrepublic.us/smoking-cessation/smoking-cessationtobacco-harm-reduction-faq/.*
[19] *http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf.*
[20] *https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf.*
[21] *http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847_corlette_why_are_many_coops_failing.pdf?la=en.*

Third, CMS regularly uses enhanced oversight plans (EOPs) and corrective action plans (CAPs) as part of our CO-OP monitoring and oversight process, as laid out in the CO-OP loan agreements and recommended by the HHS OIG. CMS places a CO-OP on an EOP or CAP when it identifies an issue that can be resolved through corrective action. A CO-OP can be on an EOP or CAP for a variety of reasons relating to its operations, compliance, management, or finances. A CAP could require a CO-OP to make improvements to its claim payment processes, customer service, premium billing, or other administrative functions. The reasons for an EOP or a CAP are often common issues for any issuer in the difficult, competitive, and complicated health insurance market, and are not unique to the CO-OPs.

Finally, CMS can terminate its loan agreement with a CO-OP if we determine it is no longer viable, sustainable, or serving the interests of the community. CMS works closely with DOIs and shares information to assist in their assessments of CO-OPs. If a loan agreement is terminated, CMS works with the State DOI and the CO-OP board to wind down operations in an orderly way to mitigate impact to the consumer. While it is too early to tell how much money may be recovered, CMS has begun the recovery process, and once the wind down of these CO-OPs is complete, we will use every available tool to recoup Federal funding, based on applicable law and the loan agreements. During closeout, most CO-OPs exiting the market were placed into a receivership or supervisory status that controls assets, expenses, and contractual rights and obligations including ongoing operating costs and claims payment. These arrangements help protect remaining funds.

In addition to protecting taxpayer dollars, CMS also works to protect consumers. For the CO-OPs that are closing, we are working closely with the CO-OP and State regulators to facilitate a smooth transition for consumers to retain access to coverage and ensure providers are reimbursed for covered services rendered to CO-OP enrollees. Affected CO-OP enrollees have access to a special enrollment period, and are able to shop for 2016 coverage on the Marketplace until February 28, 2016. In all cases, CMS is focused on making sure consumers continue to receive medical services.

CONCLUSION

Since the enactment of the Affordable Care Act, CMS has worked to increase access to quality, affordable coverage through the Marketplaces and to be responsible stewards of taxpayer dollars. The CO-OP program was designed to give consumers more choices, promote competition, and improve quality in the health insurance market. Though not all CO-OPs have continued to offer coverage, consumers continue to have a variety of affordable health insurance coverage choices that meet the health care needs of their families. CMS is committed to continuing its work with the CO-OPs offering coverage this year to facilitate progress and expand into new markets when appropriate. Working with State DOIs and the CO-OPs, CMS will continue its rigorous ongoing monitoring and oversight processes in order to prevent consumers from experiencing potential disruption in health insurance coverage. Additionally, we will use every tool available to recoup Federal dollars, where appropriate. We appreciate the committee's interest, and I am happy to answer your questions.

PREPARED STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

When Congress wrote the Affordable Care Act, it gave Americans shopping for insurance the option of getting coverage from new, private, non-profits called Consumer Operated and Oriented Plans, or CO-OPs.

More than a million people turned to CO-OPs for insurance in 2015—including many deeply vulnerable people who needed access to top-notch care. That tells me that there is big demand for CO-OPs, and lawmakers should be focused on making sure CO-OPs provide the services that consumers require.

That's not how events have played out. Even though the Supreme Court has upheld the ACA multiple times, the political battles have continued, and CO-OPs are one of the big targets.

Right out of the gate, CO-OP funding was cut by two-thirds. Their financial flexibility was the next thing to go. Congress denied the ability to move resources that would help new CO-OPs weathering growing pains to continue serving consumers.

So from very early on, these private insurance plans have been facing extraordinarily stiff headwinds.

In Oregon, 15,000 people got insurance coverage from Health Republic, one of our State's two CO-OPs. It fell victim to this totally avoidable financial crunch and announced last October that it was closing—due in large part to the inability of Congress to set politics aside and work together to improve the law.

Fortunately, there is still a marketplace where those 15,000 Oregonians can shop for high-quality insurance. And there are several more CO-OPs up and running across the country, including the second one in my home State, called Oregon's Health CO-OP.

Some want to paint the CO-OPs as a kind of token failed government program, but the facts don't bear that out. Let's remember what CO-OPs are and what they are not. They are not government-run, and they are not the "Public Option" that was at the center of the ACA debate 6 years ago. CO-OPs are private, market-driven plans that now cover hundreds of thousands of Americans.

In my view, these CO-OPs are start-ups that had early investors. They attracted customers. They drew up business plans and opened their doors. Then their investments were yanked away. It's no wonder some of them have run into trouble.

Congress ought to be looking for ways to strengthen CO-OPs and stoke private competition in insurance marketplaces nationwide so that consumers have more choices.

The fact is, by now, the battle lines over the Affordable Care Act are familiar to just about everybody. The House and Senate have taken dozens and dozens of votes on proposals that undermine or repeal the ACA. But here's the bottom line—the United States is not going back to the dark days when health care was reserved for the healthy and the wealthy.

So independent of the ACA debate, Congress should come together on a bipartisan basis to take on the big challenges this country faces in health care. For example, Senator Grassley and I spent 18 months working on a bipartisan inquiry into the pricing of blockbuster Hepatitis C drugs called Sovaldi and Harvoni. Figuring out how Americans will afford prescription drugs in the future is going to take serious work that will only be successful if done in a bipartisan way.

There's also meaningful progress being made to address what I see as the biggest challenge facing Medicare. That's providing high-quality care to seniors who have chronic conditions like Alzheimer's, cancer and diabetes. Our system today is not built to provide care for chronic conditions in a smart, coordinated way.

Democrats and Republicans should come together to fix it, and I've been proud to work with Chairman Hatch and Senators Isakson and Warner to bring a chronic care bill before the Finance Committee.

In short, this committee has an opportunity to start pulling on the same end of the rope when it comes to the big challenges in health care. With this hearing kicking off our work on health policy in 2016, I look forward to working with my colleagues in the weeks and months ahead.

Finally, I'd like to thank Acting CMS Administrator Andy Slavitt for joining the Finance Committee here today. Mr. Slavitt is an excellent nominee for the job of CMS Administrator, and in the last 6 months since he was officially nominated, he has proven himself on the job. I think it's about time that this committee move Mr. Slavitt's nomination through the process as quickly as possible.

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